

Facility Name & ID Number Odd Fellow Rebekah Home

0010223 Report Period Beginning: 07/01/14 Ending: 06/30/15

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	162	Skilled (SNF)	162	59,130	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	162	TOTALS	162	59,130	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	26,153	12,569	5,641	44,363	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,153	12,569	5,641	44,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.03%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 1977

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 162 and days of care provided 5,641

Medicare Intermediary WPS

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	369,850	43,518		413,368		413,368		413,368		1
2	Food Purchase		395,911		395,911		395,911		395,911		2
3	Housekeeping	185,911	31,212		217,123		217,123		217,123		3
4	Laundry	68,975	13,886		82,861		82,861		82,861		4
5	Heat and Other Utilities			215,538	215,538		215,538		215,538		5
6	Maintenance	174,973	102,177	50,393	327,543		327,543		327,543		6
7	Other (specify):*										7
8	TOTAL General Services	799,709	586,704	265,931	1,652,344		1,652,344		1,652,344		8
	B. Health Care and Programs										
9	Medical Director			11,668	11,668		11,668		11,668		9
10	Nursing and Medical Records	2,403,233	176,932	10,439	2,590,604		2,590,604		2,590,604		10
10a	Therapy		292,337	845,477	1,137,814	(331,548)	806,266		806,266		10a
11	Activities	127,040	12,343		139,383		139,383		139,383		11
12	Social Services	88,122		4,586	92,708		92,708		92,708		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,618,395	481,612	872,170	3,972,177	(331,548)	3,640,629		3,640,629		16
	C. General Administration										
17	Administrative	100,583			100,583		100,583		100,583		17
18	Directors Fees										18
19	Professional Services			480,778	480,778		480,778	(13,633)	467,145		19
20	Dues, Fees, Subscriptions & Promotions			159,256	159,256	(88,695)	70,561	(46,582)	23,979		20
21	Clerical & General Office Expenses	319,010	32,743	30,354	382,107		382,107		382,107		21
22	Employee Benefits & Payroll Taxes			1,021,767	1,021,767		1,021,767		1,021,767		22
23	Inservice Training & Education			7,488	7,488		7,488		7,488		23
24	Travel and Seminar			14,829	14,829		14,829	(9,830)	4,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			158,239	158,239		158,239		158,239		26
27	Other (specify):*			18,000	18,000		18,000	(18,000)			27
28	TOTAL General Administration	419,593	32,743	1,890,711	2,343,047	(88,695)	2,254,352	(88,045)	2,166,307		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,837,697	1,101,059	3,028,812	7,967,568	(420,243)	7,547,325	(88,045)	7,459,280		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			280,854	280,854		280,854		280,854			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(19,370)	(19,370)			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							(23,963)	(23,963)			34
35	Rent-Equipment & Vehicles			25,926	25,926		25,926		25,926			35
36	Other (specify):*											36
37	TOTAL Ownership			306,780	306,780		306,780	(43,333)	263,447			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					331,548	331,548		331,548			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					88,695	88,695		88,695			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					420,243	420,243		420,243			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,837,697	1,101,059	3,335,592	8,274,348		8,274,348	(131,378)	8,142,970			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	BHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(23,963)			6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(19,370)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(9,830)			19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,633)			22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(18,000)			24
25	Fund Raising, Advertising and Promotional	(46,582)			25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (131,378)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (131,378)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

Odd Fellow Rebekah Home

Report Period Beginning: 07/01/14
 Ending: 06/30/15

ID# 0010223

Sch. V Line
Reference

NON-ALLOWABLE EXPENSES

Amount

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15		0	33	15
16			24	16
17		0	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(13,633)	19	22
23				23
24		(18,000)	27	24
25		(46,582)	20	25
26				26
27		0	22	27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(78,215)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,633)	0	0	0	0	0	0	0	0	0	0	(13,633)	19
20	Fees, Subscriptions & Promotions	(46,582)	0	0	0	0	0	0	0	0	0	0	(46,582)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,830)	0	0	0	0	0	0	0	0	0	0	(9,830)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(18,000)	0	0	0	0	0	0	0	0	0	0	(18,000)	27
28	TOTAL General Administration	(88,045)	0	(88,045)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(88,045)	0	(88,045)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223

Report Period Beginning:

07/01/14 Ending:06/30/15

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,370)	0	0	0	0	0	0	0	0	0	0	(19,370)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(23,963)	0	0	0	0	0	0	0	0	0	0	(23,963)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(43,333)	0	0	0	0	0	0	0	0	0	0	(43,333)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(131,378)	0	0	0	0	0	0	0	0	0	0	(131,378)	45

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Board of Directors list attached</u>						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/14 Ending: 06/30/15

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1									\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

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07/01/14

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VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1							\$	\$			\$					
2																
3																
4																
5																
	Working Capital															
6																
7																
8																
9	TOTAL Facility Related						\$	\$			\$					
	B. Non-Facility Related*															
10	Interest Income										(19,370)					
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			(19,370)					
15	TOTALS (line 9+line14)						\$	\$			(19,370)					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2014 report.		\$			1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$			2	
3. Under or (over) accrual (line 2 minus line 1).		\$			3	
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$			4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$			6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$			7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2010	_____	8	FOR BHF USE ONLY		
	2011	_____	9			
	2012	_____	10			
	2013	_____	11			
	2014	_____	12			
				13	FROM R. E. TAX STATEMENT FOR 2014 \$ _____	13
				14	PLUS APPEAL COST FROM LINE 5 \$ _____	14
				15	LESS REFUND FROM LINE 6 \$ _____	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ _____	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Odd Fellow Rebekah Home COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0010223

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2014.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Odd Fellow Rebekah Home

0010223 Report Period Beginning:

07/01/14 Ending:

06/30/15

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,308 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$ <u>437,500</u>	1
2					2
3	TOTALS			\$ <u>437,500</u>	3

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	162			\$ 1,774,077	\$		\$	\$	4
5				151,724					5
6				1,867,245					6
7									7
8									8
Improvement Type**									
9	1979 Improvements	1979		28,527					9
10	1980 Improvements	1980		19,254					10
11	1981 Improvements	1981		45,037					11
12	1982 Improvements	1982		4,295					12
13	1983 Improvements	1983		106,089					13
14	1984 Improvements	1984		6,600					14
15	1985 Improvements	1985		34,689					15
16	1986 Improvements	1986		135,963					16
17	1987 Improvements	1987		1,732					17
18	1988 Improvements	1988		20,341					18
19	1989 Improvements	1989		322,810					19
20	1990 Improvements	1990		56,795					20
21	1991 Improvements	1991		25,089					21
22	1991 Improvements	1992		36,953					22
23	1993 Improvements	1993		16,174					23
24	1994 Improvements	1994		30,400					24
25	1995 Improvements	1995		48,815					25
26	1996 Improvements	1996		1,082,895					26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34					208,917		208,917		34
35									35
36									36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number **Odd Fellow Rebekah Home**

0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Roof	1997	\$ 349,692	\$		\$	\$	\$	37
38	Architect Fees	1997	3,203						38
39	Wallpaper	1997	2,692						39
40	Water Hydrant	1997	5,430						40
41	Sinks, Cabinets	1997	496						41
42	Baseboards	1997	350						42
43	Woodframe Shed	1997	7,704						43
44									44
45	Water Heater	1998	14,664						45
46	Painting & Wallcovering	1998	4,567						46
47	Double drive gate & locks	1998	982						47
48									48
49	Carpet cleaning	1999	919						49
50	Exterior doors	1999	1,481						50
51	Water Heater	1999	7,660						51
52	Room renovations (wall coverings, tile, electrical)	1999	5,494						52
53	Decorating	1999	1,052						53
54	Window parts	1999	541						54
55									55
56	Baseboards, wallpaper	2000	1,120						56
57	Power panels	2000	2,722						57
58	Electrical outlets	2000	561						58
59									59
60									60
61	Booster Installation	2000	2,032						61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,228,866	\$ 208,917		\$ 208,917	\$	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,228,866	\$ 208,917		\$ 208,917	\$	\$	1
2									2
3	Heat Exchanger	2002	4,724						3
4	LAN	2002	3,142						4
5	Water Heater	2002	7,397						5
6	Interior Renovations -- Entry Way	2002	7,493						6
7									7
8	Boiler	2003	1,941						8
9	Compressor	2003	6,361						9
10	Temperature control	2003	1,941						10
11	A/C Unit	2003	1,000						11
12	Smoke Detectors	2003	1,882						12
13	Lobby renovations: Wall paper, paint, floor coverings	2003	41,598						13
14	Kitchen Hood	2003	1,840						14
15	Firewall / Roof safty improvments	2003	32,502						15
16	Water Heater	2003	7,300						16
17									17
18	Lobby renovations: Wall paper, paint, floor coverings	2004	4,694						18
19	Water Heater	2004	2,516						19
20	Alzheimer Unit renovations: Wall paper, paint, floor coverings	2004	47,811						20
21	Alarm System	2004	2,863						21
22	Nurse Station	2004	29,661						22
23	Wallcoverings	2004	19,247						23
24	Wall Guards	2004	9,409						24
25	Corrodor Renovations	2004	15,153						25
26	Emergency Systems	2004	1,535						26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,480,876	\$ 208,917		\$ 208,917	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,480,876	\$ 208,917		\$ 208,917	\$	\$	1
2									2
3	Wire Access Doors	2005	3,568						3
4	Resident Room Remodel-- paint	2005	9,616						4
5	Compressor	2005	868						5
6	Grease Trap	2005	9,545						6
7	Garbage Disposal	2005	1,049						7
8	Fire Protection System	2005	3,332						8
9	2 Heat/ Cool Unit	2005	1,943						9
10	Heat Exchanger	2005	924						10
11	Security System	2005	1,095						11
12	Dinning room Remodel--Paint/Wallpaper/carpet	2005	7,114						12
13	Insurance Proceeds--roof repair	2005	(16,568)						13
14									14
15	Dinning room Remodel--Paint/Wallpaper/carpet	2006	20,984						15
16	Roof/Fence Replacement	2006	21,748						16
17	Sidewalk	2006	1,637						17
18	Remodel Therapeutic Rehab Unit	2006	28,486						18
19									19
20	Remodel Therapeutic Rehab Unit (paint, carpet, fixtures)	2007	4,343						20
21	Rooftop compressor	2007	1,362						21
22	Wiring for IT	2007	4,200						22
23	Heat Exchanger	2007	988						23
24	West Wing Remodel--Paint/Wallpaper/carpet	2007	5,534						24
25	Water Heater	2007	12,335						25
26	Roof repair	2007	1,157						26
27	Compressor	2007	1,237						27
28	HVAC unit	2007	967						28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,608,340	\$ 208,917		\$ 208,917	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,608,340	\$ 208,917		\$ 208,917	\$	\$	1
2									2
3	Compressor	2008	1,446						3
4	Bather	2008	1,673						4
5	Heat Exchanger	2008	5,760						5
6	Light Fixture	2008	812						6
7	Doors	2008	6,986						7
8	Boiler	2008	1,114						8
9	Wander Guard	2008	2,968						9
10	Floor Tile	2008	2,283						10
11	PTAC Unit	2008	971						11
12	Roof -- Harmony Corridor	2008	7,630						12
13	Vent Sleeves	2008	1,275						13
14	Blinds	2008	1,143						14
15	Fire System	2008	3,424						15
16	Compressor	2008	1,295						16
17	Ridge Vent	2008	4,330						17
18	Employee Entrance Door	2008	1,343						18
19									19
20	Hallway Floor Replacement	2009	104,987						20
21	Heat Exchanger	2009	5,714						21
22									22
23	New Roof	2010	125,051						23
24	Water Meter valve	2010	3,113						24
25	Awning Front Entrance	2010	3,630						25
26	Water Heater	2010	11,977						26
27	Paint, Floor Tiles (Rehab to Home Rooms)	2010	3,158						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,910,423	\$ 208,917		\$ 208,917	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,910,423	\$ 208,917		\$ 208,917	\$	\$	1
2									2
3	Compressor	2011	7,961						3
4	Dryer Enclosure	2011	11,862						4
5	Water Heater	2011	12,800						5
6	Concrete Patio Floor	2011	2,675						6
7									7
8	Pavillion Roof	2012	3,975						8
9	Compressor	2012	2,986						9
10	Parking Lot Patch & Seal	2012	6,923						10
11	Rooftop A/C	2012	6,305						11
12	Water Heater	2012	10,173						12
13									13
14	Therapy Room Remodel-Cabinets	2013	1,431						14
15	Therapy Room Remodel-Countertops	2013	1,062						15
16	Therapy Room Remodel-Electrical	2013	1,667						16
17	Therapy Room Remodel-Materials	2013	982						17
18	Lobby A/C	2013	3,511						18
19	Lighting Retrofit	2013	5,781						19
20	Furnaces	2013	6,998						20
21	Yale doors (8)	2013	2,942						21
22									22
23	Facility cabling for new Nurse Call System	2014	259,332						23
24	Rooftop HVAC Purchase and Installation-Main Living Area	2014	6,580						24
25	Bather acquisition and installation	2014	12,679						25
26	Air conditioner for computer room	2014	4,178						26
27	Rooftop HVAC Purchase and Installation-Kitchen	2014	8,534						27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,291,760	\$ 208,917		\$ 208,917	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,291,760	\$ 208,917		\$ 208,917	\$	\$	1
2									2
3	Carrier Rooftop Unit - Laundry	2015	6,690						3
4	Replaced Water Heater	2015	12,860						4
5	Replacement of Exterior Signage	2015	3,899						5
6	Security System Installation - Door Controls & Tag Readers	2015	6,878						6
7	Replaced Sidewalk Entrance to Front Door	2015	3,450						7
8	Installation of and Rewiring of Kitchen Receptacles	2015	3,141						8
9	Acquisition and Installation of Walk-In Freezer/Cooler	2015	48,547						9
10	New Fence for Trash Bin Area	2015	2,100						10
11	Replace Compressor - Harmony Unit - Southeast Corner	2015	6,965						11
12	Dining Hall Air Conditioner Replacements with Coils	2015	11,455						12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,397,745	\$ 208,917		\$ 208,917	\$	\$	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number **Odd Fellow Rebekah Home**

0010223

Report Period Beginning:

07/01/14

Ending:

06/30/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,957,441	\$ 71,937	\$ 71,937	\$		\$	71
72	Current Year Purchases	40,716						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,998,157	\$ 71,937	\$ 71,937	\$		\$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,833,402	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 280,854	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 280,854	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning: 07/01/14

Ending: 06/30/15

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 25,926 Description: Televisions and copiers

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Odd Fellow Rebekah Home # 0010223 Report Period Beginning: 07/01/14 Ending: 06/30/15
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$			\$ 277,378	\$		\$ 277,378	1
2	Licensed Speech and Language Development Therapist		hrs				143,652			143,652	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				384,794	442		385,236	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescripts					291,895		291,895	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify):										12
13	Other (specify):						39,653			39,653	13
14	TOTAL			\$			\$ 845,477	\$ 292,337		\$ 1,137,814	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223Report Period Beginning: 07/01/14

Ending:

06/30/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/15

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,223,411	\$	1
2	Cash-Patient Deposits	18,607		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	989,480		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	114,014		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,431,509		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,777,021	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	8,040,355		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,868,175		16
17	Accumulated Depreciation (book methods)	(7,305,379)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,603,151	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 9,380,172	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 371,166	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,607		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	366,067		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,203		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Bed Tax</u>	37,913		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 800,956	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 800,956	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 8,579,216	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,380,172	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 8,094,173	1
2	Restatements (describe):		2
3	Audit Reclassifications		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,094,173	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	485,043	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 485,043	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 8,579,216	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,167,899	1
2	Discounts and Allowances for all Levels	(3,180,116)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,987,783	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,073,431	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 3,073,431	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	24,431	16
17	Sale of Drugs	526,074	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	25,317	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 575,822	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	19,370	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,370	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Unrestricted donation</u>	100,000	28
28a	<u>Other</u>	2,985	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 102,985	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,759,391	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,652,344	31
32	Health Care	3,972,177	32
33	General Administration	2,343,047	33
B. Capital Expense			
34	Ownership	306,780	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,274,348	40
41	Income before Income Taxes (line 30 minus line 40)**	485,043	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 485,043	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Odd Fellow Rebekah Home

0010223

Report Period Beginning: 07/01/14

Ending: 06/30/15

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,803	1,898	\$ 65,614	\$ 34.57	1
2	Assistant Director of Nursing	1,809	1,904	55,181	28.98	2
3	Registered Nurses	18,751	19,738	529,750	26.84	3
4	Licensed Practical Nurses	24,111	25,380	574,775	22.65	4
5	CNAs & Orderlies	86,710	91,274	1,143,110	12.52	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,811	1,906	34,803	18.26	8
9	Activity Director					9
10	Activity Assistants	10,214	10,752	127,040	11.82	10
11	Social Service Workers	5,462	5,749	88,122	15.33	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,039	29,515	369,850	12.53	15
16	Dishwashers					16
17	Maintenance Workers	10,940	11,516	174,973	15.19	17
18	Housekeepers	15,419	16,230	185,911	11.45	18
19	Laundry	6,398	6,743	68,975	10.23	19
20	Administrator	1,976	2,080	100,583	48.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,651	14,369	319,010	22.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	227,094	239,054	\$ 3,837,697 *	\$ 16.05	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
35	Dietary Consultant	\$ 0	35
36	Medical Director	11,668	36
37	Medical Records Consultant	1,990	37
38	Nurse Consultant		38
39	Pharmacist Consultant	7,880	39
40	Physical Therapy Consultant		40
41	Occupational Therapy Consultant		41
42	Respiratory Therapy Consultant		42
43	Speech Therapy Consultant		43
44	Activity Consultant		44
45	Social Service Consultant	4,586	45
46	Other(specify)		46
47			47
48			48
49	TOTAL (lines 35 - 48)	\$ 26,124	49

C. CONTRACT NURSES

	1	2	3
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
50	Registered Nurses	\$	50
51	Licensed Practical Nurses		51
52	Certified Nurse Assistants/Aides		52
53	TOTAL (lines 50 - 52)	\$	53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function				Description	Amount	Description	Amount	
David Standerfer			\$ 100,583	Workers' Compensation Insurance	\$ 221,554	IDPH License Fee	\$		
				Unemployment Compensation Insurance	16,818	Advertising: Employee Recruitment		5,350	
				FICA Taxes	293,584	Health Care Worker Background Check (Indicate # of checks performed _____)		2,898	
				Employee Health Insurance	446,359	Patient Background Checks			
				Employee Meals		PR		22,578	
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions		11,783	
				Other Benefits	43,452	License & Fees		4,379	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 100,583			Less: Public Relations Expense		(22,578)	
B. Administrative - Other						Non-allowable advertising		(431)	
Description			Amount			Yellow page advertising	(
			\$						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$		TOTAL (agree to Schedule V, line 22, col.8)	\$ 1,021,767		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 23,979
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
Heritage Operations Group	Mgt		\$ 443,912				Out-of-State Travel	\$	
Pehlman & Dold	Audit		18,795						
Assurance Agency	Consulting		300						
ADP	Taxes		1,177				In-State Travel		
Principal Financial	403 B Plan Admin		2,961					13,779	
								24	
							Seminar Expense	1,026	
								(9,830)	
Legal adj to Zero			13,633				Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 480,778	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 4,999	

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Odd Fellow Rebekah Home# 0010223Report Period Beginning: 07/01/14Ending: 06/30/15**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. HCCI
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 88,695
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 13,895
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Pehlman & Dold
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number	Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3 Line #	Sch 5 pg 3 Col #	Sch 6 pg Adjustment Line #	Amount
1009	PETTY CASH	1,223,411				1,009	1,009 CASH 1,223,411
1010	CASH IN BANK					1,100	1,100 ACCTS R 989,480
1040	CASH IN BANK-PAYROLL					1,101	1,101 ALLOW. FOR UNCOLLECTIBL
1100	ACCOUNTS RECEIVABLE	989,480				1,110	1,110 ACCTS RECEIV-M/C
1110	MEDICARE RECEIVABLES					1,125	1,125 ACCTS RECEIV-IPA
1125	IPA INCOME RECEIVABLE					1,135	1,135 ACCTS RECEIV-IC
1130	MEDICARE COST REPORT					1,140	1,140 UNAPPLIED CASH RECEIPTS
1135	ACCOUNTS RECEIVABLE-IC					1,145	1,145 A/R SUSPENSE-REFUNDS
1140	UNAPPLIED CASH RECEIPTS					1,200	1,200 PREPAID 114,014
1145	A/R SUSPENSE-REFUNDS					1,220	1,220 OTHER PREPAID EXPENSES
1190	ACCRUED INTEREST REC					1,300	1,300 DIETARY INVENTORY
1200	PREPAID INSURANCE	114,014				1,310	1,310 SUPPLIES INVENTORY
1220	OTHER PREPAID EXPENSES					1,320	1,320 LINEN INVENTORY
1300	FOOD INVENTORY					1,409	1,409 LAND 0
1310	SUPPLIES INVENTORY					1,450	1,450 FURNITU 1,868,175
1409	LAND	0				1,460	(1,622,241)
1450	FURNITURE & EQUIPMENT	1,868,175				1,475	1,475 BUILDIN 8,040,355
1460	ACCUM DEPR-FURN & EQU	-1,622,241				1,490	1,490 ACCUM] (5,683,138)
1475	BUILDING & IMPROVEMEN	8,040,355				1,530	1,530 RESIDEN 18,607
1490	ACCUM DEPR-BUILDING	-5,683,138				1,550	1,550 LOAN FE 0
1530	RESIDENT FUNDS	18,607				1,551	1,551 LOAN FEES ADDED
1550	LOAN FEES	0				1,850	1,850 INTERCC 4,431,509
1560	REAL ESTATE TAX ESCROW					2,010	2,010 ACCOUN (371,166)
1575	REIMBURSABLE PURCHASES					2,100	2,095 BONUSES PAYABLE
1850	INTRACOMPANY	4,431,509				2,100	2,100 ACCRUE (115,495)
2010	ACCOUNTS PAYABLE	-371,166				2,100	2,100 PR CLEARING-BENEFITS
2095	BONUSES PAYABLE					2,100	2,100 PR CLEARING-LABOR
2100	ACCRUED PAYROLL	-115,495				2,110	2,110 ACCRUE (250,572)
2110	ACCRUED VACATION PAY	-250,572				2,120	2,120 U.C. TAX 0

2120	UC TAXES PAYABLE			2,125	2,125 FICA TAX	(7,203)	
2125	FICA TAX PAYABLE	-7,203	-7,203	2,130	2,130 FEDERAL W/H TAX PAYABLE		
2130	FIT PAYABLE			2,140	2,140 STATE W/H TAX PAYABLE		
2140	STATE W/H PAYABLE		0	2,152	2,152 WORKERS COMP ACCRUAL		
2145	EARNED INCOME CREDIT			2,225	2,225 EMPLOYEE INSURANCE REF		
2150	UC FED CREDIT REDUCTION			2,230	2,230 PAYROLL SAVINGS		
2230	PAYROLL SAVINGS			2,235	2,240 UNITED FUND		
2235	IRA W/HOLDINGS			2,240	2,246 GROUP INSURANCE - CAFETE		
2240	UNITED WAY			2,246	2,250 401K W/F		
2245	GROUP INSURANCE PAYABLE			2,250			
2246	GROUP INSURANCE PAYABLE-CAFETERIA			2,260	2,260 WAGE G.		
2260	WAGE GARNISHMENTS			2,300	2,300 ACCRUE	0	
2280	MISC PAYROLL DEDUCTIONS			2,320	2,320 IPA PAYM	(37,913)	
2300	ACCRUED INTEREST PAYA	0		2,350	2,350 REAL ES	0	
2310	SALES TAX PAYABLE			2,385		0	
2320	IPA PAYMENTS PAYABLE	-37,913		2,400	2,400 CURRENT PORTION OF LT DEB		
2350	REAL ESTATE TAX PAYAB	0		2,512	2,512 DUE TO 1	(18,607)	
2385	ACTIVITY FUND	0		2,600	2,600 LASALLI	0	
2390	SECURITY DEPOSITS	0		2,600			
2391	VOLUNTEER FUND			2,625	2,625 LASALLE CONSTR. LOAN #2		
2393	HEART FUND/BAZAAR			2,625			
2395	DEFERRED INC EMP & MEM			2,695	2,695 CURRENT PORTION OF LT DEB		
2400	CURRENT PORTION LT DEBT			2,720	2,720 RETAINED	(8,094,173)	
2460	INCOME TAXES PAYABLE				net income	(485,043)	
2512	DUE TO RESIDENTS	-18,607					
2600	MORTGAGE PAYABLE	0					
2650	EQUIPMENT LOAN PAYABLE				balance	<u>0</u>	
2695	CURRENT PORTION LT DEBT						
2696	DEFERRED INCOME TAXES						
2710	COMMON STOCK						
2720	RETAINED EARNINGS	-8,094,173					
2970	PROFIT/LOSS FOR PERIOD	-485,043					
3007.1	PATIENT DAYS-PRIVATE	12,569					3,007

3007.2	PATIENT DAYS-IPA	26,153						3,007
3007.3	PATIENT DAYS-MEDICARE	5,641						3,007
3007.4	PATIENT DAYS-CONVERSION							3,007
3007.5	PATIENT DAYS-LICENSED							3,007
3007.6	PATIENT DAYS-TOTAL							3,007
3010	1 BASIC CHARGE-PRIVATE &	-8,111,802	0	0	0	0		3,007
3015	1 PRIVATE ASSESSMENT TAX INCOME		0	0	0	0		3,010
3020	1 BASIC CHARGE-IPA	0	0	0	0	0		3,020
3030	1 BASIC CHARGE-MEDICARI	0	0	0	0	0		3,030
3035	4 DAY CARE/HOME CARE		0	0	0	0		3,040
3040	1 LIGHT NURSING CARE	0	0	0	0	0		3,050
3050	1 MEDIUM NURSING CARE		0	0	0	0		3,060
3060	1 HEAVY NURSING CARE		0	0	0	0		3,061
3061	1 SKILLED NURSING CARE							3,080
3080	1 NURSING SUPPLIES-PRIVA	-66,223	0	0	0	0		3,081
3081	1 NURSING SUPPLIES-IPA		0	0	0	0		3,082
3082	1 NURSING SUPPLIES MED PT A		0	0	0	0		3,083
3083	1 NURSING SUPPLIES MED PT B							3,100
3100	17 DRUGS	-526,074	0	0	0	0		3,101
3101	17 DRUGS-OTHER							3,110
3110	6 PT-PRIVATE	-3,073,431	0	0	0	0		3,111
3111	6 PT-IPA		0	0	0	0		3,112
3112	6 PT-MEDICARE PART A		0	0	0	0		3,113
3113	6 PT-MEDICARE PART B		0	0	0	0		3,140
3130	1 PUBLIC AID ASSESSMENT INC							3,150
3140	19 LABORATORY INCOME		0	0	0	0		3,151
3150	6 SPEECH/OT-PRIVATE		0	0	0	0		3,152
3151	6 SPEECH/OT-IPA		0	0	0	0		3,153
3152	6 SPEECH/OT-MED PART A		0	0	0	0		3,160
3153	6 SPEECH/OT MED PART B							3,410
3410	2 IPA DISCOUNTS	3,180,116	0	0	0	0		3,411
3411	2 MEDICAID PART B DISCOUNT		0	0	0	0		3,420
3420	2 MEDICARE DISCOUNTS		0	0	0	0		3,500

3440	36 ASSESSMENT TAX EXPENSE			42	3	0	0		3,520
3520	16 RENT INCOME	-24,431		6	0	6	-23,963		3,530
3530	13 BEAUTY SHOP	0		0	0	0	0		3,560
3560	12 ACTIVITY FUND INCOME	0		0	0	0	0		3,570
3570	12 VENDING INCOME/EXPENSE	0		0	0	0	0		3,590
3580	12 MANAGEMENT FEES			0	0	0	0		3,595
3590	1 EQUIPMENT RENTAL	10,126		0	0	0	0		3,600
3595	21 RESIDENT TRANSPORTATION	-23,430		0	0	0	0		4,110
3600	21 MISC INCOME	-1,887		0	0	0	0		4,111
4110	GENERAL & ADMINISTRATIVE WAGES	282,922	319,010	21	1	17	0		4,115
4111	ADMINISTRATOR WAGES	100,583	100,583	17	1	0	0		4,120
4115	VACATION & SICK - G&A	36,088		21	1	0	0		4,121
4120 4475	EMPLOYEE BENEFITS	11,569	1,021,767	22	3	0	0		4,130
4125	EMPLOYEE HOLIDAY VACATION	4,906		22	3	0	0		4,135
4130	EMPLOYEE SCHOLARSHIP	14,141		21	1	0	0		4,250
4135	EMPLOYEE SCHOLARSHIP	12,836		23	3	0	0		4,255
4220	DIRECTORS FEES	0	0	18	3	0	0		4,260
4250 4255	OFFICE SUPPLIES	32,743	32,743	21	2	0	0		4,275
4260	TELEPHONE	30,354	30,354	21	3	0	0		4,276
4275	TRAINING & EMPLOYEE DEVELOPMENT	7,488	7,488	23	3	16	0 **		4,280
4280	GENERAL TRAVEL	13,779	14,829	24	3	16	0		4,281
4281	MEAL EXPENSE FOR TRAVEL	24		24	3	19	0		4,285
4285	EDUCATION & SEMINAR	1,026		24	3	19	-9,830 ***		4,289
4290	HELP WANTED ADVERTISING	5,350	159,256	20	3	0	0 -88,695		4,290
4291	PROMOTIONAL ADVERTISING	23,573		20	3	25	-23,573		4,291
4292	PUBLIC RELATIONS	22,578		20	3	25	-22,578		4,292
4300	LICENSES & FEES	93,074		20	3	17	0		4,300
4310	DUES & SUBSCRIPTIONS	11,783		20	3	17	-431		4,310
4320	CONTRIBUTIONS	0		27	3	20	0		4,320
4350	PROFESSIONAL FEES	38,805	480,778	19	3	22	-13,633		4,350
4355	MEDICAL DIRECTOR	11,668	11,668	9	3	0	0		4,355
4360	UTILIZATION REVIEW	0		10	3	0	0		4,362
4361	OTHER PHYSICIAN FEES			39	3	0	0		4,363

4362	MEDICAL RECORDS CONSI	1,990		10	3	0	0	4,364
4363	PHARMACIST FEES	7,880		10	3	0	0	4,370
4364	SOC SERV/ACT CONSULT	4,586	4,586	12	3	0	0	4,383
4370	TV RENTAL	8,314		35	3	5	0	4,390
4380	INCOME TAXES		18,000	27	3	26	0	4,400
4383	BACKGROUND CHECKS	2,898		20	3	26	0	4,401
4400	PAYROLL TAXES	299,962		22	3	0	0	4,410
4401	PAYROLL TAXES ADMINIS	10,440		22	3	0	0	4,420
4410	GROUP INSURANCE	446,359		22	3	0	0	4,430
4420	LIABILITY INSURANCE	158,239	158,239	26	3	0	0	4,435
4425	INSURANCE-OWNERS			22	3	21	0	4,436
4430	WORKMENS COMP INSUR/	221,554		22	3	0	0	4,450
4450	CENTRAL OFFICE FEES	441,973		19	3	34	0 **	4,460
4460	BAD DEBTS	18,000		27	3	24	-18,000	4,461
4470	LOST ITEMS-RESIDENTS	0		27	3	0		4,470
4490	MISCELLANEOUS	0		27	3	0	0	4,475
4510	REAL ESTATE TAXES	0	0	33	3	0	0	4,486
4600	LEASED EQUIPMENT	17,612	25,926	35	3	16	0	4,490
5110	MAINTENANCE SALARIES	159,725	174,973	6	1	0	0	4,496
5120	MAINTENANCE SICK & VA	15,248		6	1	0	0	4,510
5130	ELECTRIC	117,977	215,538	5	3	0	0	4,600
5131	NATURAL GAS	30,648		5	3	0	0	5,110
5132	HEATING & DEISEL OIL			5	3	0	0	5,120
5133	WATER & SEWER	66,913		5	3	0	0	5,130
5134	TRASH COLLECTION	20,185	50,393	6	3	0	0	5,131
5140	PROPERTY PLANT REPLAC	12,679	102,177	6	2	0	0	5,133
5160	GENERAL REPAIR & MAIN'	89,498		6	2	0	0	5,134
5165	MAINTENANCE CONTRAC'	30,208		6	3	0	0	5,140
5210	DIETARY WAGES	338,177	369,850	1	1	0	0	5,160
5220	DIETARY SICK & VAC	31,673		1	1	0	0	5,165
5240	SALES TAX			2	3	13	0	5,210
5248	FOOD PURCHASES	409,806	395,911	2	2	0	0	5,220
5250	SUPPLIES-DISHWASHING	7,024	43,518	1	2	0	0	5,248

5260	DIETARY REPLACEMENT	11,354		1	2	0	0	5,250
5270	KITCHEN SUPPLIES-PAPER	25,140		1	2	0	0	5,260
5295	MEAL CREDIT	-13,895		2	2	0	0	5,270
5310	LAUNDRY WAGES	64,222	68,975	4	1	0	0	5,295
5340	LAUNDRY SICK & VAC	4,753		4	1	0	0	5,310
5370	LAUNDRY REPLACEMENT	3,047	13,886	4	2	0	0	5,340
5380	LAUNDRY REIMBURSEMENT			4	3	0	0	5,370
5390	LAUNDRY SUPPLIES	10,839		4	2	0	0	5,380
5410	HOUSEKEEPING WAGES	171,317	185,911	3	1	0	0	5,390
5440	HOUSEKEEPING SICK & VAC	14,594		3	1	0	0	5,410
5480	HOUSEKEEPING SUPPLIES	30,251	31,212	3	2	0	0	5,440
5490	HOUSEKEEPING SUPPLIES-	961		3	2	0	0	5,480
6010	RN WAGES-MEDICARE		2,403,233	10	1	0	0	5,490
6020	RN WAGES-NON MEDICAR	488,579		10	1	0	0	6,020
6030	DON WAGES	65,614		10	1	0	0	6,030
6035	ADON	55,181		10	1	0	0	6,035
6040	RN SICK & VACATION	41,171		10	1	0	0	6,040
6110	LPN WAGES-MEDICARE	534,285		10	1	0	0	6,120
6120	LPN WAGES-NON MEDICAL	0		10	1	0	0	6,140
6130	LPN WAGES OTHER			10	1	0	0	6,220
6140	LPN SICK & VACATION	40,490		10	1	0	0	6,240
6210	AIDE WAGES-MEDICARE			10	1	0	0	6,245
6220	AIDE WAGES-NON MEDICAL	1,067,316		10	1	0	0	6,246
6230	WARD CLERKS			10	1	0	0	6,247
6240	AIDE VACATION & SICK	75,794		10	1	0	0	6,250
6245	CONTRACT NURSES-RN	0		10	3	0	0	6,255
6246	CONTRACT NURSES-LPN	0		10	3	0	0	6,260
6247	CONTRACT NURSES-AIDES	0		10	3	0	0	6,270
6250	NURSE AIDE TRAINING W/	0	0	13	1	0	0	6,275
6255	NURSE AID TRAINING EXP	0	0	13	2	0	0	6,290
6260	NURSE AIDE TRAINING RE	0		0	0	0	0	6,295
6270	REHAB WAGES	31,492		10	1	0	0	6,390
6275	REHAB SICK & VAC	3,311		10	1	0	0	6,490

6280	NURSING DEPT EDUCATION			23	3	0	0	7,280
6290	NURSING SUPPLIES	155,059	176,932	10	2	0	0	7,281
6295	NURSING SUPPLIES	21,506		10	2	0	0	7,380
6390	REPLACEMENT-NURSING	367		10	2	0	0	7,391
6490	NURSING OTHER	569	10,439	10	3	0	0	7,393
7280	DRUG PURCHASES	273,819	292,337	39	2	0	0 ***	7,510
7281	DRUG PURCHASES-OTHER	18,076		39	2			7,540
7380	LABORATORY SERVICES	39,653	845,477	39	3	0	0	7,590
7410	HOME HEALTH SALARY			39	1	0	0	7,620
7440	HOME HEALTH SICK & VAC			39	1	0	0	7,660
7450	HOME HEALTH EXPENSES			39	3	0	0	7,710
7510	ACTIVITES WAGES	118,782	127,040	11	1	0	0	7,720
7540	ACTIVITIES SICK & VAC	8,258		11	1	0	0	7,730
7590	ACTIVITIES SUPPLIES	12,343	12,343	11	2	0	0	7,740
7595	ACTIVITIES FEES	0	0	11	3	0	0	7,750
7610	PT WAGES			39	1	0	0	7,770
7611	PT SICK & VACATION			39	1	0	0	7,820
7620	PT FEES	384,794		39	3	0	0 ***	7,890
7660	PT SUPPLIES	442		39	2	0	0	7,960
7710	SOCIAL SERVICE WAGES	79,916	88,122	12	1	0	0	8,120
7720	SOCIAL SERVICE SICK & V	8,206		12	1	0	0	8,125
7730	SOCIAL SERVICE EXPENSE	0	0	12	2	0	0	8,130
7740	OT FEE	277,378		39	3	0	0 ***	8,150
7750	SOCIAL THERAPIST FEE	0	0	12	3	0	0	9,510
7770	SPEECH THERAPY FEE	143,652		39	3	0	0 ***	9,520
7800	BEAUTICIAN WAGES		0	40	1	0	0	9,530
7810	BEAUTICIAN SICK & VAC			40	1	0	0	
7820	BEAUTICIAN FEES	0	0	40	3	0	0	
7890	BEAUTY SHOP SUPPLIES	0	0	40	2	0	0	
7910	VOLUNTEER COORDINATOR			21	1	0	0	
7940	VOL COORD SICK & VAC			21	1	0	0	
7960	VOL COORD SUPPLIES	0		21	2	0	0	
8100	RENT	0	0	34	3	0	0	

8120	INTEREST EXPENSE	0	0	32	3	14	-19,370	
8130	DEPRECIATION	280,854	280,854	30	3	9	0	
8150	LOAN FEE AMORTIZATION	0		32	3	0	0	0
9510	INTEREST INCOME	-19,370		32	0	10	0	
9520	MISC NON-OPERATING INC	-102,985		0	0	0	0	
9700	INCOME TAXES	0		0	0	0	0	
		8,151,993	8,274,348					
			122,355					

GRAND TOTALS -485,043 -131,378
(NET INCOME)

0

FACILITY NAME:

FACILITY ID: 0

FACILITY UNITS: 89

BALANCE SHEET TOTAL 0

G/L

RECAP CENSUS

PP	12,569	12,569
IPA	26,153	26,153
medicare	5,641	5,641
		44,363

ES

UND

RIA

BT

BT

3,007 PATIENT	26,153
3,007 PATIENT	5,641
	0

3,010 BASIC CI	(8,111,802)
3,020 BASIC CI	0
3,030 BASIC CI	0
	0
	0
	0
	0

3,080 NURSING	(66,223)
3,081 NURSING	0
3,082 NURSING	0
3,083 NURSING	0
3,100 DRUGS-M	(526,074)
	0

3,110 PHYSICIAN	(3,073,431)
	0

3,112 PHYSICIAN	0
3,113 PHYSICIAN	0

3,140 LABORATORY INCOME	0
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3,152 ST/OT TR	0
3,153 ST/OT TR	0

3,185 REHABILITATION/ISOLATION/OTHER CHG

3,410 IPA/OTHER	0
3,411 MEDICAL	0

3,420 MEDICAL	3,063,383
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3,520 RENT INC	(24,431)
3,530 BEAUTY	0
	0
3,570 VENDING	0
3,590 EQUIPMI	10,126
3,595 RESIDEN	(23,430)
3,600 MISC INC	(1,887)
4,110 G&A WA	282,922
4,111 ADMINIS	100,583
4,115 G&A PTC	36,088
4,120 EMPLOY	11,545
	4,906
4,130 EMPLOY	14,141
4,135 EMPLOY	12,836
4,250 OFFICE S	18,234
4,255 POSTAGI	1,335
4,260 TELEPHC	30,354
4,275 TRAININ	7,488
	889
4,280 GENERA	13,779
4,281 MEAL EX	24
4,285 EDUCAT	939
4,289 MEETING	87
4,290 HELP WA	5,350
4,291 PROMOT	23,573
4,292 PUBLIC I	22,578
4,300 LICENSE	93,074
4,310 DUES & S	11,783
4,320 CONTRIE	0
4,350 PROFESS	38,805
4,355 MEDICAL	11,668
	1,990
	7,880

4,364 SOCIAL S	4,586
4,370 TV RENT	8,314
4,383 BACKGR	2,898
4,390 OTHER T	0
4,400 PAYROL	299,962
4,401 PAYROL	10,440
4,410 GROUP I	446,359
4,420 LIABILIT	158,239
4,430 WORKM.	217,799
4,435 W/C-FIRS	550
4,436 DRUG TE	2,316
4,450 MANAGI	441,973
4,460 BAD DEF	18,000
4,461 BAD DEF	116,733
4,470 LOST ITE	0
4,475 UNIFORM	24
4,486 SERVICE	24,516
4,490 MISC EX	8,915
4,496 MISC. M.	13,174
4,510 REAL ES	0
4,600 LEASED	17,612
5,110 MAINTEI	159,725
5,120 MAINTEI	15,248
5,130 ELECTRI	117,977
5,131 NATURA	30,648
5,133 WATER &	66,913
5,134 TRASH C	20,185
5,140 PROP/PL	12,679
5,160 GENERA	89,498
5,165 MAINTEI	5,692
5,210 DIETARY	338,177
5,220 DIETARY	31,673
5,248 FOOD PU	400,891

5,250 SUPPLIE	7,024
5,260 REPLACI	11,354
5,270 KITCHEN	25,140
5,295 MEAL IN	(13,895)
5,310 LAUNDR	64,222
5,340 LAUNDR	4,753
5,370 REPLACI	3,047
	0
5,390 SUPPLIE	10,839
5,410 HOUSEK	171,317
5,440 HOUSEK	14,594
5,480 SUPPLIE	30,251
5,490 SUPPLIE	961
6,020 RN WAG	488,579
6,030 DON WA	65,614
6,035 ADON W	55,181
6,040 RN PTO &	41,171
6,120 LPN WAG	534,285
6,140 LPN PTO	40,490
6,220 AIDES W	1,067,316
6,240 AIDES PT	75,794
	0
	0
	0
6,270 REHAB V	31,492
6,275 REHAB F	3,311
6,290 NURSINC	155,059
6,295 NURSINC	21,506
6,390 REPLACI	367
6,490 OTHER	569

7,280 DRUG PU	273,819
7,281 DRUG PU	18,076
7,380 LABORA	11,944
7,390 X-RAY S	14,563
	13,146
7,510 ACTIVIT	118,782
7,540 ACTIVIT	8,258
7,590 ACTIVIT	12,343
7,620 PHYSICA	384,794
7,660 P.T. SUPE	442
7,710 SOCIAL S	79,916
7,720 SOCIAL S	8,206
7,730 SOCIAL S	0
7,740 OCCUPA	277,378
7,770 SPEECH'	143,652
7,820 BEAUTIC	0
	0
	0
8,120 INTERES	0
	0
8,130 DEPRECI	280,854
	0
9,510 INTERES	(19,370)
9,520 MISC NO	(102,985)
4,220	0
8,100	0
9,702	0
5,230	0
	<u>(485,043)</u>

Expenses Fixed Assets

**Odd Fellow Rebekah Home
2015 Cost Report
Supplemental Schedules**

1. Schedule V Line 23 - Inservice Training & Education

<u>Vendor</u>	<u>Purpose</u>	<u>Amount</u>
Relias	Health care mandatory training software modules	\$ 5,568
Providigm	Quality management tools and training modules	<u>1,920</u>
Total - Line 23 - Inservice Training & Education		\$ <u><u>7,488</u></u>

2. Schedule V - Line 10a to Line 39 - Reclassifications

<u>Line Item</u>	<u>Amount</u>
Purchased Drugs and Medications	\$ 291,895
Purchased Hospital Services	13,146
Purchased Laboratory Services	11,944
Purchased Radiology Services	<u>14,563</u>
Amount Reclassified to Line 39	\$ <u><u>331,548</u></u>

2. Schedule V - Line 20 to Line 42 - Reclassification

<u>Line Item</u>	<u>Amount</u>
Provider Participation Fee	\$ <u><u>88,695</u></u>